

Advanced Relief Chiropractic & Acupuncture
405 West Oak St.
Denton, TX 76201

Patient Information:

Date: _____

Name _____
First Middle Last

Address _____
Street City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Occupation: _____ - _____

Date of Birth: ____/____/____ Age: ____ Soc. Sec. # ____ - ____ - ____

Sex: M ____ F ____ Marital Status: ____ S ____ M ____ D ____ W Number of Children: _____

In Emergency Notify: _____ Relationship: _____ Phone: _____

How did you hear about our clinic? () Friend/Relative: _____

() Direct Mail () Location or Walk by () Website () Yellow Pages () Other

Medical Contact Information:

Family Physician: _____ Office Phone: _____

Chiropractor: _____ Office Phone: _____

Other: _____ Office Phone: _____

Insurance:

Insurance Type: Health Personal Pay PI/Auto Worker's Comp Medicare

Insurance Name: _____

Member #: _____ Group #: _____

Insurer's Name (if different from patient): _____

Insurer's DOB: ____/____/____ Insurer's Soc. Sec. #: ____ - ____ - ____

Insurer's Employer: _____

Person responsible for the account: _____

Patient Name: _____

Today's Visit:

What is your major symptom? _____

2nd symptom? _____ 3rd symptom? _____

4th symptom? _____ Other: _____

When was the first time you noticed this problem? _____

If this is a reoccurrence, when was the first time you noticed this problem? _____

How did it originally occur? _____

Has it become worse recently? _____ If yes, when and how? _____

How frequent is this condition? _____ Constant _____ Daily _____ Intermittent _____ Night only

How long does it last? _____ All day _____ Few hours _____ Minutes

Is there anyone in your family with the same/similar problems? _____

What do you feel is the cause(s) of your symptoms? _____

Does this problem interfere with any daily activities? (Work, Sleep, Sex, etc...) _____

If so, how much? _____

Have you been given a diagnosis for this problem? If so, what? _____

What kind of treatment have you tried? _____

What makes this problem worse? _____

() Standing () Sitting () Lying () Bending () Lifting () Twisting () _____

What do you do to relieve this problem? _____

Describe your pain today: () Sharp () Dull () Numbness () Tingling () Aching

() Burning () Stabbing Other: _____

No Symptoms

Extreme Symptoms

Place an X on the line above to indicate your level of pain today.

Within the last 3 months have you had any of the following:

Skin & Hair: _____ Rashes _____ Ulcerations _____ Hives _____ Itching _____ Eczema _____ Pimples _____ Dandruff

_____ Dry Skin _____ Recent Moles _____ Loss of Hair _____ Purpura _____ Night Sweats _____ Fevers _____ Sweat Easily

_____ Chills _____ Change in hair or skin texture Other? _____

Musculoskeletal: _____ Joint disorders _____ Weak Muscles _____ Pain/Soreness in muscles _____ Tremors

_____ Difficult walking _____ Cold hands/feet _____ Swelling of hands/feet _____ Back Pain _____ Spinal curvature

_____ Hernia _____ Numbness _____ Tingling _____ Paralysis _____ Neck tightness _____ Neck Pain _____ Shoulder Pain

_____ Hand/wrist pain _____ Hip pain _____ Knee Pain _____ Sprain of joint _____ Localized weakness _____ Poor balance

Other? _____

Head, eyes, ears, nose, and throat: _____ Dizziness _____ Concussions _____ Migraines _____ Glasses/lens _____ Eye

Stain _____ Eye Pain _____ Color Blindness _____ Night Blindness _____ Cataracts _____ Poor vision

_____ Blurry Vision _____ Earaches _____ Ringing in ears _____ Poor hearing _____ Spots in front of eyes

_____ Sinus problems _____ Nose bleeding _____ Sore throat _____ Grinding teeth _____ Teeth problems _____ Facial pain

_____ Jaw clicks _____ Sores on lips/tongue _____ Difficulty swallowing Other? _____

Patient Name: _____

Cardiovascular: ___ High blood pressure ___ Low blood pressure ___ Chest pain ___ Palpitation ___ Fainting
___ Phlebitis ___ Irregular heartbeat ___ Rapid heartbeat ___ Varicose veins Other? _____

Respiratory: ___ Cough ___ Coughing blood ___ Wheezing ___ Difficulty in breathing ___ Bronchitis
___ Pneumonia ___ Chest Pain ___ Production of phlegm – what color? _____ Other? _____

Gastrointestinal: ___ Nausea ___ Vomiting ___ Diarrhea ___ Constipation ___ Gas ___ Belching
___ Black stools ___ Blood in stools ___ Indigestion ___ Bad breath ___ Rectal Pain ___ Hemorrhoids
___ Abdominal pain/cramps ___ Gallbladder problems ___ Parasites ___ Chronic laxative use
Bowel movements: Frequency _____ Color _____ Odor _____ Texture/form _____

Neuro-psychological: ___ Poor sleeping ___ Fatigue ___ Sudden Energy Drop ___ Loss of balance
___ Lack of coordination ___ Concussion ___ Depression ___ Anxiety ___ Stress ___ Bad temper ___ Bi-polar

Genito-urinary: ___ Pain on urination ___ Frequent urination ___ Blood in urine ___ Urgent to urinate
___ Kidney stones ___ Unable to hold urine ___ Dribbling ___ Pause of flow ___ Frequent urinary tract infection
___ Pain in general ___ Itching of genital Other? _____

Dietary: ___ Poor appetite ___ Cravings ___ Change in appetite ___ Weight loss ___ Weight gain ___ Strong thirst

Female: ___ **Are you pregnant?** ___ **Do you practice birth control?** If yes, what type and for how long? _____
___ **First date of last period** ___ **Number of pregnancies** ___ Frequent vaginal infections ___ Pelvic infection
___ Endometriosis ___ Vaginal discharge ___ Fibroids ___ Ovarian cysts ___ Irregular periods ___ Clots
___ Pain/cramps/prior/during periods ___ Breast tenderness ___ Breast lumps ___ Fertility problems ___ Hot flashes
___ Moodiness related to periods ___ Number of births ___ Miscarriages ___ Abortions ___ Premature births
___ Cesareans ___ Difficult delivery Age of first menses ___ Duration of periods ___ days, cycle ___ days

Male: ___ Prostate problems ___ Discharge ___ Impotence ___ Frequent seminal emission ___ Fertility problems
___ Ejaculation problems ___ Painful/swollen testicles Other? _____

Occupation:

Place of Work: _____ How Long? _____

Do you usually work: () Indoors () Outdoors Hours per day: _____

Occupational stresses: (Chemical, physical, psychological, etc.) _____

Personal:

Height: _____ Weight now: _____ Weight one year ago: _____ Weight max & year: _____

Habits: Do you smoke? () Yes () No What? _____ How many per day? _____

Began Smoking when? _____ Recreational Drugs? () Yes () No What? _____

Do you exercise regularly? () Yes () No Please describe your exercise program: _____

How many hours do you sleep in general? _____ What time do you go to bed? _____

Patient Name: _____

Diet:

How much coffee do you drink? _____ cups/day; Colas _____ #/day; Tea _____ cups/day

What kind of alcoholic beverages do you drink? _____ # of drinks/week: _____

How much water do you drink per day? _____ Are you a vegetarian? ()Yes ()No

Do you eat a lot of spicy food? ()Yes ()No Additional remarks/info: _____

Please describe your average daily diet: (Please be as specific as possible)

Morning: _____

Afternoon: _____

Evening: _____

Snacks: _____

Family Medical History:

Cancer _____ Diabetes _____ Hepatitis _____ Hypertension _____ Stroke _____ Heart Disease _____

Asthma _____ Alcoholism _____ Miscarriage _____ Other: _____

Past Medical History:

(Please include the month/year when the diagnosis was established)

Cancer _____ Diabetes _____ Hepatitis _____ Thyroid Disease _____

Seizures _____ Fibromyalgia _____ Arthritis _____ Tuberculosis _____

HIV/Aids _____ Heart Disease _____ Hypertension _____ Anemia _____

Emotional Imbalance _____ Breathing Problems _____

Digestive Disorders Other: (Please specify) _____

Surgeries: _____

Hospitalization: _____

Significant Trauma: (Accidents/Injuries) _____

Broken Bones / Dates: _____

Allergies: (Drugs, chemicals, foods) _____

Medications taken within the last two months (Include vitamins, OTC drugs, include dosages) _____

Have you ever received acupuncture before? If so, where? _____

Doctor's Signature _____ Date: _____